(h) *Referrals.* If a regional office is unclear in any case as to whether a condition is a covered birth defect, it may refer the issue to the Director of the Compensation and Pension Service for determination.

(i) *Effective dates.* Except as provided in § 3.114(a) or paragraph (i)(1) or (2) of this section, VA will award the monetary allowance under subchapter II of 38 U.S.C. chapter 18, for an individual with disability resulting from one or more covered birth defects, based on an original claim, a claim reopened after final disallowance, or a claim for increase, as of the date VA received the claim (or the date of birth if the claim is received within one year of that date), the date entitlement arose, or December 1, 2001, whichever is later. Subject to the condition that no benefits may be paid for any period prior to December 1, 2001:

(1) VA will increase benefits as of the earliest date the evidence establishes that the level of severity increased, but only if the beneficiary applies for an increase within one year of that date.

(2) If a claimant reopens a previously disallowed claim based on corrected military records, VA will award the benefit from the latest of the following dates: the date the veteran or beneficiary applied for a correction of the military records; the date the disallowed claim was filed; or, the date one year before the date of receipt of the reopened claim.

(j) *Reductions and discontinuances.* VA will generally reduce or discontinue awards under subchapter II of 38 U.S.C. chapter 18 according to the facts found except as provided in §§ 3.105 and 3.114(b).

(1) If benefits were paid erroneously because of beneficiary error, VA will reduce or discontinue benefits as of the effective date of the erroneous award.

(2) If benefits were paid erroneously because of administrative error, VA will reduce or discontinue benefits as of the date of last payment.

(Authority: 38 U.S.C. 501, 1811, 1812, 1813, 1814, 1815, 1816, 1821, 1822, 1823, 1824, 5101, 5110, 5111, 5112)

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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AK88

Health Care for Certain Children of Vietnam Veterans—Covered Birth Defects and Spina Bifida

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: This document proposes to establish regulations regarding health care benefits for women Vietnam veterans' children with covered birth defects. It would revise the current regulations regarding health care for Vietnam veterans' children suffering from spina bifida to also encompass health care for women Vietnam veterans' children with certain other birth defects. This is necessary to provide health care for such children in accordance with recently enacted legislation. The revisions would also reduce the requirements for preauthorization, reflect changes in organizational and personnel titles, revise contact information for the VHA Health Administration Center, and make nonsubstantive changes for purposes of clarity. Companion documents entitled ''Monetary Allowances for Certain Children of Vietnam Veterans; Identification of Covered Birth Defects'' (RIN 2900–AK67) and ''Vocational Training for Certain Children of Vietnam Veterans—Covered Birth Defects and Spina Bifida'' (RIN 2900–AK90) are set forth in the Proposed Rules section of this issue of the **Federal Register**.

DATES: Comments must be received by VA on or before February 1, 2002, except that comments on the information collection provisions in this document must be received on or before March 4, 2002.

ADDRESSES: Mail or hand deliver written comments to: Director, Office of Regulations Management (02D), Room 1154, 810 Vermont Ave., NW, Washington, DC 20420; or fax comments to (202) 273–9289; or e-mail comments to *OGCRegulations@mail.va.gov.* Comments should indicate that they are submitted in response to ''RIN 2900–AK88.'' All comments received will be available for public inspection in the Office of Regulations Management, Room 1158, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays). In addition, see the Paperwork Reduction Act heading under the **SUPPLEMENTARY INFORMATION** section of this preamble regarding submission of comments on the information collection provisions.

FOR FURTHER INFORMATION CONTACT: Susan Schmetzer, Chief, Policy & Compliance Division, VHA Health Administration Center, Department of Veterans Affairs, P.O. Box 65020, Denver, CO 80206, telephone (303) 331–7552.

SUPPLEMENTARY INFORMATION: Prior to the enactment of Public Law 106–419 on November 1, 2000, the provisions of 38 U.S.C. chapter 18 only concerned benefits for children with spina bifida who were born to Vietnam veterans. Effective December 1, 2001, section 401 of Public Law 106–419 amends 38 U.S.C. chapter 18 to add benefits for women Vietnam veterans' children with certain birth defects (referred to below as ''covered birth defects'').

As amended, 38 U.S.C. chapter 18 provides for three separate types of benefits for women Vietnam veterans' children who suffer from covered birth defects as well as for Vietnam veterans' children who suffer from spina bifida: (1) Monthly monetary allowances for various disability levels; (2) provision of health care needed for the child's spina bifida or covered birth defects; and (3) provision of vocational training and rehabilitation.

This document proposes to amend VA's ''Medical'' regulations (38 CFR part 17) by revising the regulations in §§ 17.900 through 17.905 concerning the provision of health care. These regulations currently only concern the provision of health care for Vietnam veterans' children with spina bifida. This document proposes to revise the regulations by adding women Vietnam veterans' children with covered birth defects to the existing regulatory framework. The revisions would also reduce the requirements for preauthorization, reflect changes in organizational and personnel titles, revise contact information for the VHA Health Administration Center, and make nonsubstantive changes for purposes of clarity. As the proposed rule provides, the mailing address for the VHA Health Administration Center for spina bifida is P.O. Box 65025, Denver, CO 80206–9025 and for covered birth defects is P.O. Box 469027, Denver, CO 80246–9027.

As a condition of eligibility for the provision of health care for women Vietnam veterans' children with covered birth defects, it is proposed that the child must be an *individual* determined to have a *covered birth defect* under 38 CFR 3.815. (Definitions of the terms *individual* and *covered birth defect* and provisions concerning

identification of covered birth defects are included in proposed § 3.815 set forth in the companion document concerning monetary allowances and identification of covered birth defects (RIN 2900–AK67) published in the Proposed Rules section of this issue of the **Federal Register**.)

Consistent with the authorizing legislation, a note to the proposed rule explains that the proposed provisions are not intended to be a comprehensive insurance plan and do not cover health care unrelated to spina bifida and covered birth defects.

The statutory provisions state that the Secretary may provide health care directly or by contract or other arrangement with any health care provider. VA proposes to contract or arrange for provision of covered health care only through approved health care providers. In this regard, it is proposed that such health care providers be only those currently approved, for the services provided, by the Center for Medicare and Medicaid Services (CMS), Department of Defense (DoD) TRICARE program, Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), or Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or currently approved under a license or certificate issued by a governmental entity with jurisdiction. This appears to provide reasonable assurance that individuals providing health care for these children under this authority are qualified to do so. These provisions already apply to the regulations concerning the provision of health care for Vietnam veterans' children with spina bifida, except that they reflect a title change in the Department of Defense program; clarify that approved health care providers include those issued a license or certificate by a governmental entity with jurisdiction; and clarify the definition of *respite care* by stating that the care must be furnished by an approved health care provider.

The proposal includes a note clarifying when VA is the exclusive payer for health care provided. The note states that VA would provide payment under the proposal only for health care relating to spina bifida or covered birth defects (under the definitions of *spina bifida* and *covered birth defects* in proposed § 17.900, this includes complications or medical conditions that according to the scientific literature are associated with spina bifida or with the covered birth defects). The note also states that VA is the exclusive payer for services authorized under this proposal regardless of any third-party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage. The note further states that any third-party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage would be responsible according to its provisions for payment for health care not relating to spina bifida or covered birth defects.

It is proposed as a condition of payment that preauthorization from a benefits advisor of the VHA Health Administration Center be required, in accordance with prescribed procedures, for rental or purchase of durable medical equipment with a total rental or purchase price in excess of $300, respectively; transplantation services; mental health services; training; substance abuse treatment; dental services; and travel (including any necessary costs for meals and lodging en route, and accompaniment by an attendant or attendants) other than mileage at the General Services Administration rate for privately owned automobiles. This will help VA provide necessary care under its statutory authority. Except for the following changes these preauthorization provisions already apply to children with spina bifida. The proposal would remove the requirement for preauthorization related to case management, home care, and respite care. The VHA Health Administration Center's experience has found that case management, home care, and respite care are approved in the vast majority of cases and review of these services prior to their provision has not resulted in a change to the overall outcome of care or expenses. Preauthorization would continue to be required for the rental or purchase of durable medical equipment, however, it is proposed that it not be required for the rental or purchase of equipment with a total rental or purchase price of $300 or less, respectively. The VHA Health Administration Center's experience has shown that requiring preauthorization for durable medical equipment with a rental or purchase price of $300 or less is not cost-effective for the government. The proposal also reflects a change in title of VHA Health Administration Center personnel.

Under the proposal, payment to approved health care providers would be made using the methodology already established for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) (see 38 CFR 17.270 *et seq.*). We believe this methodology based on Medicare and DoD principles would result in fair payments and allow VA to utilize a payment mechanism already in place. Use of the CHAMPVA payment methodology is currently a requirement under the regulations for spina bifida health care.

It is proposed that claims from approved health care providers be submitted to the VHA Health Administration Center for payment and that the claims contain specified information. The Center already provides claims processing services for eligible veterans' dependents under CHAMPVA and the spina bifida program. The specified information is necessary to make determinations concerning authorization for payment.

The proposal also includes time frames for submission of claims to ensure an orderly and efficient payment system. It is proposed that claims must be filed no later than one year after the date of service; or in the case of inpatient care, one year after the date of discharge; or in the case of retroactive approval for health care, 180 days following beneficiary notification of eligibility. Further, it is proposed that in response to a request for payment, VA will provide an explanation of benefits to ensure that VA determinations of payments would be understood by claimants. This already applies to spina bifida health care and is consistent with other VA health care programs for veterans' dependents.

The proposal sets forth a review and appeal process concerning determinations relating to the provision of health care or payment. A note states that the final decision of the VHA Health Administration Center Director, concerning provision of health care or payment, will inform the claimant of further appellate rights for an appeal to the Board of Veterans' Appeals. This already applies to spina bifida health care, except that the review and appeal process reflects a change in title of an organizational unit.

Consistent with the statutory scheme, we propose that payments made will constitute payment in full. Accordingly, providers will not be permitted to bill the patient for charges in excess of the VA-determined allowable amount. The proposed rule also includes a specific list of items that would be excluded from payment since we believe they were not intended to be subject to payment. This already applies to spina bifida health care.

The proposal includes provisions concerning medical records. It is proposed that copies of medical records generated outside VA that relate to activities for which VA is asked to provide payment or that VA determines are necessary to adjudicate claims under

§§ 17.900 through 17.905 must be provided to VA at no charge when requested by VA. This already applies to spina bifida health care.

Paperwork Reduction Act of 1995

Under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520), this proposed rule contains information collections in proposed 38 CFR 17.902 through 17.904. These sections concern the provision of certain health care for Vietnam veterans' children with spina bifida or children born with certain other birth defects to women Vietnam veterans. VA is proposing to revise the information collection currently approved by the Office of Management and Budget (OMB) under control number 2900–0578 to substitute the information collections in proposed 38 CFR 17.902 through 17.904 for the information collections currently approved for those sections of the regulations. Accordingly, under section 3507(d) of the Act VA has submitted a copy of this rulemaking action to OMB for its review.

OMB assigns a control number for each collection of information it approves. VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

Comments on the collections of information contained in this proposed rule should be submitted to the Office of Management and Budget, Attention Desk Officer for the Department of Veterans Affairs, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies sent by mail or hand delivery to the Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Ave. NW, Room 1154, Washington, DC 20420; by fax to (202) 273–9289; or by e-mail to *OGCRegulations@mail.va.gov*. Comments should indicate that they are submitted in response to ''RIN 2900–AK88.'' All written comments to VA will be available for public inspection in the Office of Regulations Management, Room 1158, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays).

Preauthorization—Section 17.902

Title: Preauthorization for Provision of Health Care for Certain Children of Vietnam Veterans.

Summary of collection of information: The provisions of proposed 38 CFR 17.902 would require individuals to submit to a benefits advisor of the VHA Health Administration Center a preauthorization request for health care consisting of rental or purchase of durable medical equipment with a rental or purchase price in excess of $300, respectively; mental health services; training; substance abuse treatment; dental services; transplantation services; or travel (other than mileage at the General Services Administration rate for privately owned automobiles). The preauthorization request would contain the child's name and Social Security number; the veteran's name and Social Security number; the type of service requested; the medical justification; the estimated cost; and the name, address, and telephone number of the provider.

Type of review: Revision of currently approved collection.

Description of need for information and proposed use of information: Such information would be necessary to make preauthorization determinations in accordance with proposed 38 CFR 17.902.

Description of likely respondents: Individuals seeking provision of health care to certain children of Vietnam veterans.

Estimated number of respondents: 400.

Estimated frequency of responses: Occasionally.

Estimated total annual reporting and recordkeeping burden: 200 hours.

Estimated burden per respondent: 30 minutes (2 × 15 minutes).

Payment of Claims—Section 17.903

Title: Payment of Claims for Provision of Health Care for Certain Children of Vietnam Veterans.

Summary of collection of information: The provisions of proposed 38 CFR 17.903 would require that, as a condition of payment, claims from ''approved health care providers'' for health care provided under 38 CFR 17.900 through 17.905 must include the following information, as appropriate: with respect to patient identification information: the patient's full name, Social Security number, address, and date of birth; with respect to provider identification information (inpatient and outpatient services): full name and address (such as hospital or physician), remittance address, address where services were rendered, individual provider's professional status (M.D., Ph.D., R.N., etc.), and provider tax identification number (TIN) or Social Security number; with respect to patient treatment information (longterm care or institutional services): dates of service (specific and inclusive); summary level itemization (by revenue code); dates of service for all absences from a hospital or other approved institution during a period for which inpatient benefits are being claimed; principal diagnosis established, after study, to be chiefly responsible for causing the patient's hospitalization; all secondary diagnoses; all procedures performed; discharge status of the patient; and institution's Medicare provider number; with respect to patient treatment information for all other health care providers and ancillary outpatient services: diagnosis, procedure code for each procedure, service, or supply for each date of service, and individual billed charge for each procedure, service, or supply for each date of service; with respect to prescription drugs and medicines: name and address of pharmacy where drug was dispensed, name of drug, National Drug Code (NDC) for drug provided, strength, quantity, date dispensed, and pharmacy receipt for each drug dispensed.

Type of review: Revision of currently approved collection.

Description of need for information and proposed use of information: Such information would be necessary to make payment determinations in accordance with proposed 38 CFR 17.903.

Description of likely respondents: Individuals seeking payment for provision of health care for certain children of Vietnam veterans.

Estimated number of respondents: 3,000.

Estimated frequency of responses: 10.

Estimated total annual reporting and recordkeeping burden: 3,000 hours.

Estimated burden per respondent: 60 minutes (10 × 6 minutes).

Review and Appeal Process—Section 17.904

Title: Review and Appeal Process Regarding Provision of Health Care or Payment Relating to Provision of Health Care for Certain Children of Vietnam Veterans.

Summary of collection of information: The provisions of proposed 38 CFR 17.904 would establish a review process regarding disagreements by a Vietnam veteran's child or representative with a determination concerning authorization of health care or a health care provider's disagreement with a determination regarding payment. The person or entity requesting reconsideration of such determination would be required to submit such request to the VHA Health Administration Center (Attention: Chief, Benefit and Provider Services), in writing within one year of the date of initial determination. The request must state why the decision is in error and include any new and relevant information not previously considered. After reviewing the matter, a benefits

advisor would issue a written determination to the person or entity seeking reconsideration. If such person or entity remains dissatisfied with the determination, the person or entity would be permitted to make a written request for review by the Director, VHA Health Administration Center.

Type of review: Revision of currently approved collection.

Description of need for information and proposed use of information: The information proposed to be collected under § 17.904 appears to be necessary to make review and appeal determinations.

Description of likely respondents: Beneficiaries and providers disagreeing with determinations regarding covered services and benefits.

Estimated number of respondents: 200.

Estimated frequency of responses: 3.

Estimated total annual reporting and recordkeeping burden: 200 hours.

Estimated burden per respondent: 60 minutes (3 × 20 minutes).

The Department considers comments by the public on proposed collections of information in—

• Evaluating whether the proposed collections of information are necessary for the proper performance of the functions of the Department, including whether the information will have practical utility;

• Evaluating the accuracy of the Department's estimate of the burden of the proposed collections of information, including the validity of the methodology and assumptions used;

• Enhancing the quality, usefulness, and clarity of the information to be collected; and

• Minimizing the burden of the collections of information on those who are to respond, including responses through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

OMB is required to make a decision concerning the collection of information contained in this proposed rule between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication. This does not affect the deadline for the public to comment on the proposed regulations.

Comment Period

We are providing, except for comments on the information collection provisions, a comment period of 30 days for this proposed rule due to the December 1, 2001, effective date of the new benefit programs enacted by section 401 of Public Law 106–419, the statutory requirement for a final rule prior to that date, and the need to have a final rule as soon as possible in order to avoid delay in the commencement of those benefits. We are providing for the information collections in this document a 60-day comment period pursuant to the Paperwork Reduction Act.

Executive Order 12866

This document has been reviewed by the Office of Management and Budget under Executive Order 12866.

Regulatory Flexibility Act

The Secretary hereby certifies that the adoption of the rule would not have a significant impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. It is estimated that there are only a total of 1200 Vietnam veterans' children who suffer from spina bifida and women Vietnam veterans' children who suffer from covered birth defects. They are widely geographically diverse and the health care provided to them would not have a significant impact on any small businesses. Therefore, pursuant to 5 U.S.C. 605(b), this document is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Unfunded Mandates

The Unfunded Mandates Reform Act requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in an expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million or more in any given year. This rule would have no consequential effect on State, local, or tribal governments.

Catalog of Federal Domestic Assistance

There are no Catalog of Federal Domestic Assistance program numbers for the programs affected by this document.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Grant programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Approved: October 26, 2001.

Anthony J. Principi,

Secretary of Veterans Affairs.

For the reasons set forth in the preamble, 38 CFR part 17 is proposed to be amended as follows:

PART 17—MEDICAL

1. The authority citation for part 17 continues to read as follows:

Authority: 38 U.S.C. 501(a), 1721, unless otherwise noted.

2. In part 17, the undesignated center heading immediately preceding § 17.900 and §§ 17.900 through 17.905 are revised to read as follows:

Health Care Benefits for Certain Children of Vietnam Veterans—Spina Bifida and Covered Birth Defects

§ 17.900 Definitions.

For purposes of §§ 17.900 through 17.905—

Approved health care provider means a health care provider currently approved by the Center for Medicare and Medicaid Services (CMS), Department of Defense TRICARE Program, Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Joint Commission on Accreditation of Health Care Organizations (JCAHO), or currently approved for providing health care under a license or certificate issued by a governmental entity with jurisdiction. An entity or individual will be deemed to be an approved health care provider only when acting within the scope of the approval, license, or certificate.

Child for purposes of spina bifida means the same as *individual* as defined at § 3.814(c)(2) or § 3.815(c)(2) of this title and for purposes of covered birth defects means the same as *individual* as defined at § 3.815(c)(2) of this title.

Covered birth defects means the same as defined at § 3.815(c)(3) of this title and also includes complications or medical conditions that are associated with the covered birth defects according to the scientific literature.

Habilitative and rehabilitative care means such professional, counseling, and guidance services and such treatment programs (other than vocational training under 38 U.S.C. 1804 or 1814) as are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of a disabled person.

Health care means home care, hospital care, nursing home care, outpatient care, preventive care,

habilitative and rehabilitative care, case management, and respite care; and includes the training of appropriate members of a child's family or household in the care of the child; and the provision of such pharmaceuticals, supplies (including continence-related supplies such as catheters, pads, and diapers), equipment (including durable medical equipment), devices, appliances, assistive technology, direct transportation costs to and from approved health care providers (including any necessary costs for meals and lodging en route, and accompaniment by an attendant or attendants), and other materials as the Secretary determines necessary.

Health care provider means any entity or individual that furnishes health care, including specialized clinics, health care plans, insurers, organizations, and institutions.

Home care means medical care, habilitative and rehabilitative care, preventive health services, and health-related services furnished to a child in the child's home or other place of residence.

Hospital care means care and treatment furnished to a child who has been admitted to a hospital as a patient.

Nursing home care means care and treatment furnished to a child who has been admitted to a nursing home as a resident.

Outpatient care means care and treatment, including preventive health services, furnished to a child other than hospital care or nursing home care.

Preventive care means care and treatment furnished to prevent disability or illness, including periodic examinations, immunizations, patient health education, and such other services as the Secretary determines necessary to provide effective and economical preventive health care.

Respite care means care furnished by an approved health care provider on an intermittent basis for a limited period to an individual who resides primarily in a private residence when such care will help the individual continue residing in such private residence.

Spina bifida means all forms and manifestations of spina bifida except spina bifida occulta (this includes complications or medical conditions that are associated with spina bifida according to the scientific literature).

Vietnam veteran for purposes of spina bifida means the same as defined at § 3.814(c)(1) or § 3.815(c)(1) of this title and for purposes of covered birth defects means the same as defined at § 3.815(c)(1) of this title.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1821)

§ 17.901 Provision of health care.

(a) *Spina bifida.* VA will provide a Vietnam veteran's child who has been determined under § 3.814 or § 3.815 of this title to suffer from spina bifida with such health care as the Secretary determines is needed by the child for spina bifida. VA may inform spina bifida patients, parents, or guardians that health care may be available at not-for-profit charitable entities.

(b) *Covered birth defects.* VA will provide a woman Vietnam veteran's child who has been determined under § 3.815 of this title to suffer from spina bifida or other covered birth defects with such health care as the Secretary determines is needed by the child for the covered birth defects. However, if VA has determined for a particular covered birth defect that § 3.815(a)(2) of this title applies (concerning affirmative evidence of cause other than the mother's service during the Vietnam era), no benefits or assistance will be provided under this section with respect to that particular birth defect.

(c) *Providers of care.* Health care provided under this section will be provided directly by VA, by contract with an approved health care provider, or by other arrangement with an approved health care provider.

(d) *Submission of information.* For purposes of §§ 17.900 through 17.905:

(1) The telephone number of the VHA Health Administration Center is (888) 820–1756;

(2) The facsimile number of the VHA Health Administration Center is (303) 331–7807;

(3) The hand-delivery address of the VHA Health Administration Center is 300 S. Jackson Street, Denver, CO 80209; and

(4) The mailing address of the VHA Health Administration Center—

(i) For spina bifida is P.O. Box 65025, Denver, CO 80206–9025; and

(ii) For covered birth defects is P.O. Box 469027, Denver, CO 80246–9027.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1821)

Note to § 17.901: This is not intended to be a comprehensive insurance plan and does not cover health care unrelated to spina bifida or unrelated to covered birth defects. VA is the exclusive payer for services paid under §§ 17.900 through 17.905 regardless of any third party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage. Any third-party insurer, Medicare, Medicaid, health plan, or any other plan or program providing health care coverage would be responsible according to its provisions for payment for health care not relating to spina bifida or covered birth defects.

§ 17.902 Preauthorization.

(a) Preauthorization from a benefits advisor of the VHA Health Administration Center is required for the following services or benefits under §§ 17.900 through 17.905: rental or purchase of durable medical equipment with a total rental or purchase price in excess of $300, respectively; transplantation services; mental health services; training; substance abuse treatment; dental services; and travel (other than mileage at the General Services Administration rate for privately owned automobiles). Authorization will only be given in those cases where there is a demonstrated medical need related to the spina bifida or covered birth defects. Requests for provision of health care requiring preauthorization shall be made to the VHA Health Administration Center and may be made by telephone, facsimile, mail, or hand delivery. The application must contain the following:

(1) Name of child,

(2) Child's Social Security number,

(3) Name of veteran,

(4) Veteran's Social Security number,

(5) Type of service requested,

(6) Medical justification,

(7) Estimated cost, and

(8) Name, address, and telephone number of provider.

(b) Notwithstanding the provisions of paragraph (a) of this section, preauthorization is not required for a condition for which failure to receive immediate treatment poses a serious threat to life or health. Such emergency care should be reported by telephone to the VHA Health Administration Center within 72 hours of the emergency.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1821)

§ 17.903 Payment.

(a)(1) Payment for services or benefits under §§ 17.900 through 17.905 will be determined utilizing the same payment methodologies as provided for under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) (see § 17.270).

(2) As a condition of payment, the services must have occurred:

(i) For spina bifida, on or after October 1, 1997, and must have occurred on or after the date the child was determined eligible for benefits under § 3.814 of this title.

(ii) For covered birth defects, on or after December 1, 2001, and must have occurred on or after the date the child was determined eligible for benefits under § 3.815 of this title.

(3) Claims from approved health care providers must be filed with the VHA Health Administration Center in writing

(facsimile, mail, hand delivery, or electronically) no later than:

(i) One year after the date of service; or

(ii) In the case of inpatient care, one year after the date of discharge; or

(iii) In the case of retroactive approval for health care, 180 days following beneficiary notification of eligibility.

(4) Claims for health care provided under the provisions of §§ 17.900 through 17.905 must contain, as appropriate, the information set forth in paragraphs (a)(4)(i) through (a)(4)(v) of this section.

(i) Patient identification information:

(A) Full name,

(B) Address,

(C) Date of birth, and

(D) Social Security number.

(ii) Provider identification information (inpatient and outpatient services):

(A) Full name and address (such as hospital or physician),

(B) Remittance address,

(C) Address where services were rendered,

(D) Individual provider's professional status (M.D., Ph.D., R.N., etc.), and

(E) Provider tax identification number (TIN) or Social Security number.

(iii) Patient treatment information (long-term care or institutional services):

(A) Dates of service (specific and inclusive),

(B) Summary level itemization (by revenue code),

(C) Dates of service for all absences from a hospital or other approved institution during a period for which inpatient benefits are being claimed,

(D) Principal diagnosis established, after study, to be chiefly responsible for causing the patient's hospitalization,

(E) All secondary diagnoses,

(F) All procedures performed,

(G) Discharge status of the patient, and

(H) Institution's Medicare provider number.

(iv) Patient treatment information for all other health care providers and ancillary outpatient services such as durable medical equipment, medical requisites, and independent laboratories:

(A) Diagnosis,

(B) Procedure code for each procedure, service, or supply for each date of service, and

(C) Individual billed charge for each procedure, service, or supply for each date of service.

(v) Prescription drugs and medicines and pharmacy supplies:

(A) Name and address of pharmacy where drug was dispensed,

(B) Name of drug,

(C) National Drug Code (NDC) for drug provided,

(D) Strength,

(E) Quantity,

(F) Date dispensed,

(G) Pharmacy receipt for each drug dispensed (including billed charge), and

(H) Diagnosis for which each drug is prescribed.

(b) Health care payment will be provided in accordance with the provisions of §§ 17.900 through 17.905. However, the following are specifically excluded from payment:

(1) Care as part of a grant study or research program,

(2) Care considered experimental or investigational,

(3) Drugs not approved by the U.S. Food and Drug Administration for commercial marketing,

(4) Services, procedures, or supplies for which the beneficiary has no legal obligation to pay, such as services obtained at a health fair,

(5) Services provided outside the scope of the provider's license or certification, and

(6) Services rendered by providers suspended or sanctioned by a Federal agency.

(c) Payments made in accordance with the provisions of §§ 17.900 through 17.905 shall constitute payment in full. Accordingly, the health care provider or agent for the health care provider may not impose any additional charge for any services for which payment is made by VA.

(d) Explanation of benefits (EOB). When a claim under the provisions of §§ 17.900 through 17.905 is adjudicated, an EOB will be sent to the beneficiary or guardian and the provider. The EOB provides, at a minimum, the following information:

(1) Name and address of recipient,

(2) Description of services and/or supplies provided,

(3) Dates of services or supplies provided,

(4) Amount billed,

(5) Determined allowable amount,

(6) To whom payment, if any, was made, and

(7) Reasons for denial (if applicable).

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1821)

§ 17.904 Review and appeal process.

For purposes of §§ 17.900 through 17.905, if a health care provider, child, or representative disagrees with a determination concerning provision of health care or with a determination concerning payment, the person or entity may request reconsideration. Such request must be submitted in writing (by facsimile, mail, or hand delivery) within one year of the date of the initial determination to the VHA Health Administration Center (Attention: Chief, Benefit and Provider Services). The request must state why it is believed that the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for dispute will be returned to the sender without further consideration. After reviewing the matter, including any relevant supporting documentation, a benefits advisor will issue a written determination (with a statement of findings and reasons) to the person or entity seeking reconsideration that affirms, reverses, or modifies the previous decision. If the person or entity seeking reconsideration is still dissatisfied, within 90 days of the date of the decision he or she may submit in writing (by facsimile, mail, or hand delivery) to the VHA Health Administration Center (Attention: Director) a request for review by the Director, VHA Health Administration Center. The Director will review the claim and any relevant supporting documentation and issue a decision in writing (with a statement of findings and reasons) that affirms, reverses, or modifies the previous decision. An appeal under this section would be considered as filed at the time it was delivered to the VA or at the time it was released for submission to the VA (for example, this could be evidenced by the postmark, if mailed).

Note to § 17.904: The final decision of the Director will inform the claimant of further appellate rights for an appeal to the Board of Veterans' Appeals.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1821)

§ 17.905 Medical records.

Copies of medical records generated outside VA that relate to activities for which VA is asked to provide payment or that VA determines are necessary to adjudicate claims under §§ 17.900 through 17.905 must be provided to VA at no cost.

(Authority: 38 U.S.C. 101(2), 1802–1803, 1811–1813, 1821)

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